**Author’s response to reviews**

**Title:** Implementation of a Multidisciplinary Discharge Videoconference for Children with Medical Complexity: A Pilot Study

**Authors:**

Noga Ravid (nravid@stanford.edu)

Kayla Zamora (kayla.zamora@ucsf.edu)

Roberta Rehm (roberta.rehm@ucsf.edu)

Megumi Okumura (megumi.okumura@ucsf.edu)

John Takayama (john.takayama@ucsf.edu)

Sunitha Kaiser (sunitha.kaiser@ucsf.edu)

**Version:** 2 **Date:** 16 Jan 2020

**Author’s response to reviews:**

Reviewer 1

The authors did a nice job of providing point-by-point responses to the reviewer critiques. Where data was requested but lacking, I hope they will consider collecting it in their future work.

-We thank you for this feedback. We hope to collect richer data in future iterations, taking into account the information requested.
I still do think that a conceptual model of how the intervention will make a clinical impact is important (though okay to not include at this stage in the review process)—too often people have ideas about how to change practice patterns (i.e. it seems like good idea) without a clear outline of how it will actually impact health and health utilization (i.e. where is the cause and effect). Efforts at care coordination for CMC are a perfect example, since it's done thinking it will help reduce Ed visits/readmissions often just leads to increased use of under-accessed outpatient resources but doesn't actually decrease ED/readmissions because of the faulty logic that just by making appointments with doctors will always improve CMC health. The future work of these authors should focus not just on improved recruitment efforts/implementation but on being very clear on the core question of how their intervention is actually impacting health outcomes/utilization for CMC. Be wary of doing this backwards -- you should test the implementation after you have a good sense that an intervention has evidence of being effective rather than the other way around. An intervention that does not actually impact its outcome can be perfectly implemented but not move the needle at all on the actual outcome. Overall though, the review addresses the concerns outlined by the reviewers.

- We thank you for raising this excellent point. The core question of the intervention’s impact on health outcomes and utilization for CMC is essential. We hope that the information and experience gained from this pilot will help us to explore this crucial question in future iterations.

Reviewer 2

The authors have done a great job integrating feedback and the manuscript is much improved. Particularly, the addition of a new paragraph about adoption and Table 1 are much appreciated and could be very informative for both clinicians and researchers interested in videoconferencing for discharge. Some minor recommendations below.

-We thank you for this feedback.
Methods:

Page 5 lines 106-108: If I missed this section, I apologize, but it seems that the authors still do not explicitly state that videoconference as a mode of communication is the only difference between usual care and the intervention, although this is stated in their response to reviewers. For those interested in replicating this study, these details will be extremely helpful to ensure intervention fidelity. I would recommend explicitly stating that the only difference between usual care discharge planning and the intervention was that one was (I presume) via phone and faxed discharge summary? and the other was via videoconference +/- faxed discharge summary. And that the covered topics for either scenario are those in the nationally recognized framework, if this is the case.

-We apologize as this addition was erroneously omitted. It has been added as planned.

I would also recommend moving details about the intervention to the "study design" section rather than procedures.

-This information has now been combined into a single “study design” section.

Results:

Lines 139-140: It could be helpful to state how frequently the hospitalists who received the email surveys responded to them. Although not crucial, this would give the audience an idea of how acceptable this mode is for identifying appropriate patients for videoconferencing.

-We agree that this data would be valuable; however, they were not collected with this level of granularity and so we unfortunately cannot add this information.

Discussion:

Line 235: It may help the reader to have a ":" after "including."

-This has been added.

To save on word count, there are additional places were children with medical complexity could be abbreviated to CMC.
-“Children with medical complexity” has now been abbreviated to “CMC” in all appropriate places.

Lines 272-278: Not every reader will know the “H2O” study. It may be more meaningful to summarize what the study did rather than use the name of the study group and include any observations they had about your implementation outcomes. i.e. "A large pediatric RCT evaluating the impact of post-discharge phone calls found..." Then you could state, "In our study we used pre-discharge communication that included the PCP and utilized videoconferencing, which we found...."

-This section has been re-worded to summarize the study without naming it, and include outcome observations with comparison to our own study.

The addition of Table 1 definitely adds to the paper. Good job.

-We thank you for this feedback.

Table 4: Make the quotes not left aligned rather than centered. Rather than having to state PCP/Caregiver above each column, consider just labeling the entire column "Caregiver" and "PCP" and be consistent with which is in the left column and which in the right.

-This change has been made.

Figure 2. CONSORT: change "screened" to "screening" to be consistent with the other labels.

-This change has been made.